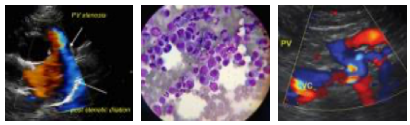
IMAGING PERFORMED BY

IntraPet.com



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DATE

9/6/22

PATIENT

Charlie Congdon

SPECIES

Canine

BREED

Labrador

SEX

Male, neutered

AGE

12/1/2013

WEIGHT

76 lbs.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

HOSPITAL NAME

Madonna VC

REFERRING VET

Dr. Brockett

INVOICE

13928

PRESENTING CLINICAL SIGNS

Inappetence and lethargy about 5 days duration. Weight loss from 92 lbs in Feb to 76 lbs. Unremarkable physical exam. No pain on abdominal palpation. No history of dietary indiscretion. No vomiting or diarrhea.

Current Medications: Amoxiclav 375 mg 1 tab po q12h, carprofen 75 mg 1 tab po q12h
Lab Results: BUN – 39, Creat - 1.8, Ca - 15.9, Tbil - 1.7, Platelets low but clumping present.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.87 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (7.92 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (7.09 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.75 cm at cranial pole) (0.81 cm at caudal pole) (3.27 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is prominent at the cranial pole and normal in size at the caudal pole with a slightly irregular shape (1.14 cm at cranial pole) (0.67 cm at caudal pole) (4.02 cm in length). A 1.65 x 1.38 cm isoechoic to slightly heterogeneous nodule is observed at the cranial aspect. The lesion causes capsular expansion. Glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.25 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of gravity-dependent echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS
Primary Findings:

- The splenic parenchymal changes could be consistent with a benign process (i.e., lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation). Alternatively, infiltrative neoplasia (i.e., round cell tumor) may be present.

- The hepatic parenchymal changes are non-specific and could be associated with benign age-related remodeling. Alternatively, infiltrative neoplasia (i.e., round cell tumor) is possible. Inflammatory disease is considered less likely in the face of the normal ALT.

Secondary Findings:

- The right adrenal nodule could be consistent with benign nodular hyperplasia or an emerging tumor.

- Bilateral, age-related chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
- Given the patient's clinical history and the presence of hypercalcemia, consider the following:

    1. Three-view thoracic radiographs to assess for occult neoplasia in the chest.

    2. Fine needle aspirates of the spleen +/- liver, if clotting status is appropriate.

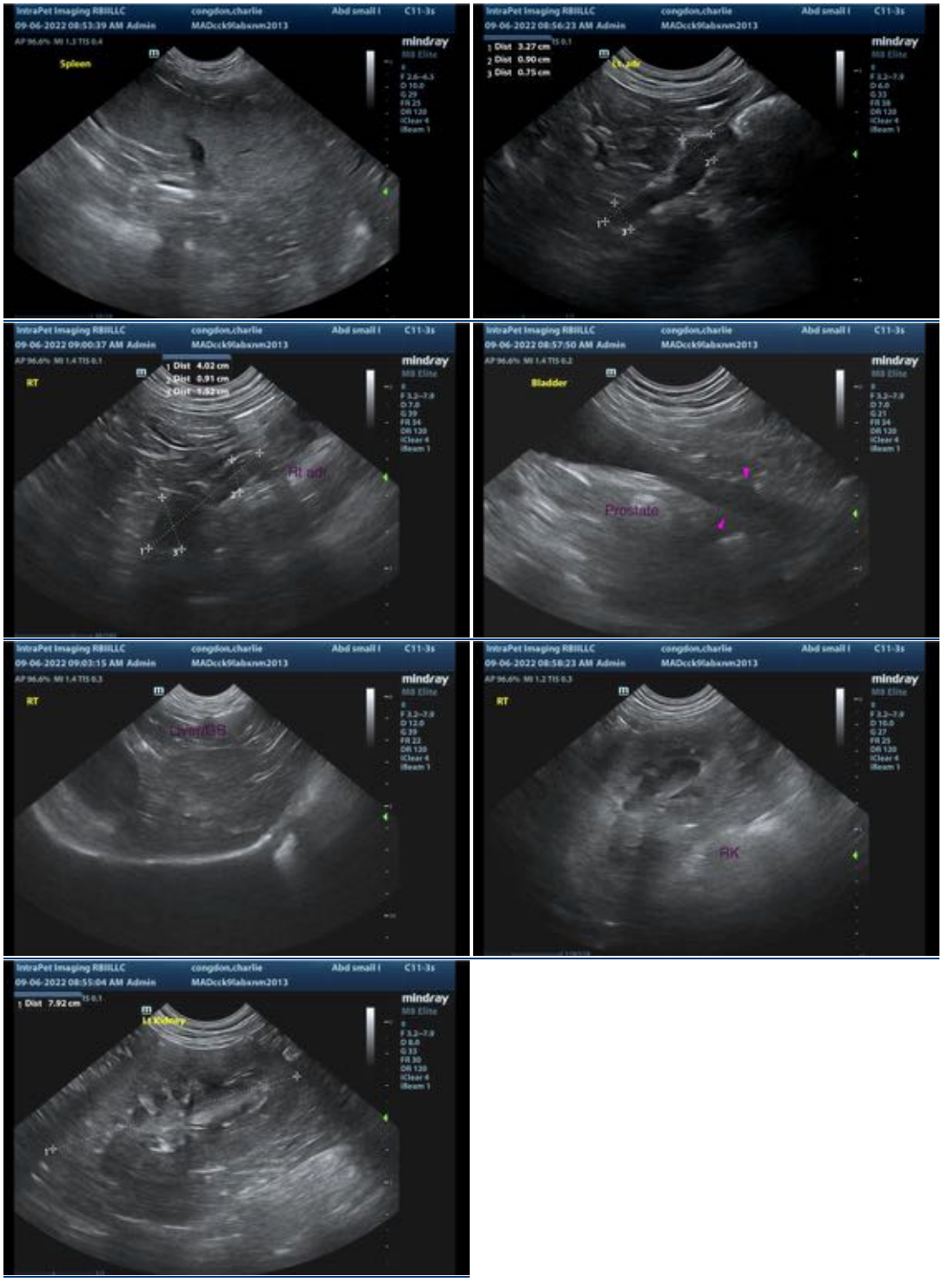
    3. Thorough rectal examination to assess for anal gland tumors.

    4. +/- PTH/PTHRP/ionized calcium.

    5. Given the azotemia, a urinalysis is recommended, if not already performed.

    6. Also consider initiation of a prescription renal diet, if the patient will tolerate it.

- Regarding the right adrenal nodule, consider a recheck ultrasound in 6-8 weeks to assess for growth.



The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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